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## **Connecting visions and voices: Involving service users in realizing 'good mental health care'**

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## CHAPTER 9

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### **Towards integration of service user knowledge in mental healthcare in low and middle-income countries: insights from Transition Theory**

#### **Abstract**

Service user involvement is promoted worldwide as a strategy to have a more needs-based and more responsive mental healthcare. However, there is limited knowledge about the role of service users in low and middle income countries. In this paper, we explore the potential of service user involvement in developing 'good' mental healthcare in LMICs. This is done using Transition Theory, by outlining barriers and opportunities in terms of the dominant structure, culture and practice of a mental healthcare system and how they relate to integration of service user knowledge. Current situations are described thereby providing insight into regime factors that hamper knowledge integration. Some important hampering factors include: the lack of mental health policy, legislation and resources, stigma and power differences between professionals and service users. In addition, the envisioned changes are elaborated upon, signifying identified facilitators and possible opportunities for change at the niche level and landscape level. Opportunities for integration of service user knowledge might be found in adopting rights-based, wellbeing-oriented approaches thereby connecting to broader societal trends. In addition, adopting strategies of deepening, broadening and scaling-up of current initiatives at the niche level might enhance shift towards integration of service user knowledge.

## Introduction

As a consequence of the broadening scope of mental health and the growing attention for the global context of mental health, increasing numbers of stakeholders are involved in developing and realizing 'good' mental healthcare. Within this multi-stakeholder setting, it is increasingly important and more relevant to integrate knowledge from different stakeholder groups. Determining what is considered as 'good' care depends on the knowledge, needs, and values of the stakeholders involved, who often have different perspectives on this. Communication and negotiation between those stakeholders is necessary in order to jointly define and realize 'good care' (Abma et al., 2009). In particular, involvement of service users is promoted worldwide as a strategy to have a more needs-based and more responsive mental healthcare system. Service user involvement in healthcare service planning and evaluation is thought to increase the quality of care, mainly because users are experts about their own illness and care, and their experiential knowledge complements professional knowledge (Thornicroft & Tansella, 2005). However, the uptake of service user involvement faces a number of challenges, in particular the fact that many researchers and practitioners weigh objectivity and evidence-based practices more heavily when making decisions about care, which might lead to the exclusion of subjective, experience-based knowledge introduced by service users (Telford and Faulker, 2004). As service users have traditionally had a weaker voice in comparison to mental health professionals and researchers, power inequalities are another challenge to bringing in knowledge from service users to the forefront (Thornicroft and Tansella, 2005).

In recent years, service user involvement is gaining ground globally. The World Health Organization (WHO, 2001) is an important proponent of service user involvement, as one of their main recommendations in their seminal World Health Report *Mental health: New Understanding, New Hope*, is to involve communities, families and consumers in the development and decision making of mental health policies, programmes and services. Scholars have specifically proposed service user involvement as a way of strengthening weak mental healthcare systems in low and middle-income countries (LMICs) by becoming more needs-based and responsive (Saraceno et al., 2007). However, actual initiatives of service user involvement in LMICs are scarcely described in the literature. At present, service user involvement in mental healthcare predominantly occurs in high-income regions, in diverse aspects of care, although still at a modest scale (Tait and Lester, 2005). In LMICs some initiatives are emerging in the context of service user networks or associations, self-help groups, advocacy and education (Katontoka, 2007; Saraceno et al., 2007).

As mental healthcare systems shift from models of valuing practitioner knowledge to models valuing different forms of converging knowledge, including knowledge

contributed by service users, it is important to capture the existing structures, cultures and practices in place within mental health systems that may hamper or facilitate this transition to a more service-user centred care. This paper aims to capture this transition, by exploring on a conceptual level how progress towards incorporating service user knowledge is changing. We use Transition Theory (Rotmans and Loorbach, 2010) as a conceptual framework to describe the current context, shifts within structures, culture and practices and pathways for change in systems in LMICs.

### **Towards a needs-based and responsive mental healthcare: a transition perspective**

For service user knowledge to be able to contribute to a more needs-based and more responsive mental healthcare system, significant changes in these systems are required, affecting the way things are structured as well as ways of working and thinking. It implies that greater value has to be attributed to the experience-based knowledge of service user and that this has to be integrated into different aspects of mental healthcare. From the perspective of Transition Theory, such a change in the (mental) health system can be considered a transition. Rotmans and Loorbach (2010, p109) defined a transition as “a fundamental change in structure, culture and practices of the respective system”. Transition theory has been applied to a wide range of social systems (e.g. agriculture, energy, mobility) and is more recently used to describe transitions in healthcare (Broerse and Bunders, 2010).

Within transition theory, systems or parts of systems (also referred to as constellations) are characterized in terms of structure, culture and practice (Rotmans and Loorbach, 2010). *Structure* refers to how people organize the things they do, either physically, institutionally or financially, while *culture* refers to ways of thinking, mental models and perceptions. *Practice* involves what people actually do; how they work and behave. Within a system or constellation, structure and culture may enable or constrain the practices of actors involved in the constellation. The actors can be individuals or groups acting in unity, who play an important role in relation to the constellation. Their actions make up the practices in the constellation, and their choices are influenced by the structure and culture within the constellation, but they also influence these aspects to some extent themselves. The constellation as a whole determines the societal role of the constellation: it produces goods, but also determines the meaning of those goods within the system at large and in society. A transition within the system implies a fundamental change of structure, culture and practice (Rotmans & Loorbach, 2010). In other words, for service user involvement to be able to contribute to a mental health system which is more needs-based and more responsive, changes need to take place in terms of structure, culture and practice.

A concept which is considered important for understanding transitions in social systems is the multi-level perspective, distinguishing three levels of social organization (Geels and

Schot, 2007): the *landscape* level refers to the broader societal trends and contexts of transitions, such as demographics, culture, and values. The *regime* level encompasses the dominant structure, culture and practices through which actors interact. At the *niche* level, actors experiment with innovations in the systems. Within social systems regimes have a stabilizing function by guiding the actions and ways of thinking within the system. However, trends at the landscape level as well as innovations at the niche level can put pressure on dominant regimes, resulting in an urgency to change the dominant structure, culture and practice. Such transitions do not happen overnight, because regimes, and solution pathways within regimes, are resistant to change. As a result, transition processes might cover two or three generations.

In this paper, we aim to capture the processes that can facilitate or hamper transitions towards integration of service user knowledge within mental health systems in LMICs identified in literature. Literature searches were performed using Google Scholar and Pubmed. Search terms included: mental healthcare, psychiatry, service user, patient, involvement, participation, low and middle-income countries, developing countries. The searches provided a number of themes influencing service user involvement in LMICs, which were divided into three categories: structure, culture and practice. For each category, themes are subdivided according to the system-level at which they operate: hampering themes at the regime level and facilitating themes at the landscape and niche level. In the next sections, the themes identified through the literature are discussed in terms of structure, culture and practice. First, current regime issues are briefly described thereby providing insight into regime factors hampering knowledge integration. Thereafter, the envisioned transition is elaborated upon, signifying relevant landscape trends and opportunities for change at the niche level. Table 9.1 provides an overview of the different themes.

Table 9.1: *Hampering and facilitating themes related to structure, culture and practice*

	<b>The current regime: hampering themes</b>	<b>A shift towards service user knowledge integration: facilitating themes</b>
<i>Structure</i>	<ul style="list-style-type: none"> <li>- lack of mental health policy and programs</li> <li>- lack of resources</li> <li>- focus on institution-based care</li> </ul>	<ul style="list-style-type: none"> <li>- focusing on community-based care</li> <li>- adopting right-based approaches</li> <li>- developing user networks and associations</li> </ul>
<i>Culture</i>	<ul style="list-style-type: none"> <li>- dominance of the biomedical model</li> <li>- influence of stigma</li> </ul>	<ul style="list-style-type: none"> <li>- integrating local concepts of mental health</li> <li>- recognizing traditional models of care</li> <li>- focusing on wellbeing</li> </ul>
<i>Practice</i>	<ul style="list-style-type: none"> <li>- limited collaboration between different stakeholders</li> <li>- professional-service user power differences</li> <li>- human rights violations</li> </ul>	<ul style="list-style-type: none"> <li>- establishing inter-sectoral collaborations</li> <li>- changing roles and behaviour of mental health professionals</li> <li>- addressing socio-economic needs</li> </ul>

## Structure

### *The current regime: hampering themes*

Three important relating themes mentioned in the literature include: the lack of mental health policy and programs, a lack of resources, and a focus on institution-based care.

In many LMICs mental health policy and programs are absent (Saxena et al., 2007), and, even with the presence of a well-formulated policy in place, LMICs often have difficulties in implementing policies and programmes. In the absence of such fundamental structures, there is a limited arena for integrating service user knowledge, as knowledge in general is not secured in the formal system. In other words, opportunities for utilizing service user knowledge might not be available because there simply is no infrastructure for it in formal mental healthcare. In addition, mental health legislation is absent or outdated in many countries. If legislation is in place, no provisions are made aimed at strengthening the position of service users, through, for example, client committees in institutions.

A second example of a dominant structure in mental health systems is human and financial resources, and the way in which these resources are allocated and organised. Many LMICs face the issue of scarce resources, including human resources, lack of facilities and services, and funding (Saraceno et al., 2007). As previously mentioned, the lack of resources, and lack of (or absorption of) funding in particular, is one of the main reasons for both the paucity of mental health services in LMICs, and slow reform of mental health systems. This also negatively affects potential reforms towards integration of service user knowledge as resources are needed to realize this shift.

Furthermore, structures (e.g. procedures and incentives) are largely institution-based despite the promotion of community-based care, because of a lack of priority on the policy agenda and lack of funding needed to effectuate these changes (Saxena et al., 2007). The fact that structures remain institution-based, contributes to maintaining the centralized, specialized and hierarchical character of mental healthcare. However, professionals working in such a setting are not so much inclined to participate in multidisciplinary settings and give room for integration of other types of knowledge (Schuitmaker, 2010).

### *A shift towards service user knowledge integration: facilitating themes*

Through synthesising the existing literature on service user knowledge, three main themes emerged which provide insight into the factors that (potentially) facilitate integration of service user knowledge. These themes include: focus on community-based care, adopting right-based approaches and development of user networks and associations. These themes are connected to broader landscape changes in healthcare, but also exemplify some initiatives at the niche level. Both the landscape changes and niche initiatives put pressure on current regimes. Relevant changes at the landscape level include the increasing decentralization of healthcare (Saltman et al., 2007) and growing public and user involvement in healthcare (Tomes, 2006).

First, over the last few decades, there has been much attention for the development of community-based services aiming to reduce institutionalized care, thereby decentralizing care. Although this shift is occurring at limited speed in LMICs, current experiences and core principles indicate that such a setting would provide more space for service user knowledge as opposed to institutionalized care. Community-oriented care is characterized by a focus on needs, community participation, self-help and empowerment, and limited professional involvement (Thornicroft, 2010). An interesting development is the increased implementation of task-shifting – a strategy promoted for LMICs (Patel, 2009) that aims to address the lack of human resources inherent in health systems in LMICs by delivering interventions through lay health workers, making it a cost-effective solution. Task-shifting requires a reduction in the value attributed to professional knowledge and instead shifts these tasks to lay workers who hold substantial experiential and/or community knowledge. One could argue that this type of setting would allow for more space to consider and work with different forms of knowledge, including experiential knowledge contributed by service users. However, this requires a re-conceptualisation of resource flows to be receptive and open to providing resources to community and service user initiatives rather than institutions.

A second structure-related factor involves the growing attention to rights-based approaches to mental healthcare (Drew et al., 2005). Scholars, professionals and user movements are increasingly seeking a rights-based approach in order to improve mental health systems in LMICs through developing new laws. Mental health laws adopted with the aim of promoting rights of persons with mental illness may stimulate the embedding of different types of knowledge, such as experiential knowledge, into different levels of the mental health system. An example of such an initiative is the recent development of the ‘Convention on the Rights of People with Disabilities’ which formed a push in mandating involvement of service users, making it a priority for all persons with disabilities – including mental illnesses - to actively participate in society, especially in their care (WHO, 2010).

The user movement in healthcare has also stimulated the development of user networks and associations for people with mental illnesses and their caregivers during the last decade (Katontoka, 2007). For a long time such networks were almost non-existent, while currently, they can be found across the world and increasing in size, serving as platforms for channelling and disseminating knowledge held by service users. They also have an important role in advocacy and establishment of self-help groups. For example, an initiative undertaken by the international NGO BasicNeeds in Ghana, has helped to form 239 user-led groups at community, district and national levels. Since then, Ghana has a registered national user association with a secretariat representing their needs at national as well as international level (BasicNeeds, 2009). Another example of service user involvement in changing structures is found in Uganda where service users are contributing to relevant policy debates and legislative processes, addressing policy gaps at

local and national levels (Kayiira, 2010). In addition, service users in Uganda were involved in reviewing the outdated 1964 Mental Health Treatment Act. The recent impetus to reform mental health policy and legislation in a number of LMICs provides an opportunity for integrating service user knowledge in developing structures (Flisher et al., 2007). However, integration of service user knowledge should be agreed on and incorporated in the early phases of policy development processes (Kleintjes et al. 2010). The absence of such structures could be seen as an opportunity for innovation at the niche level to develop, as structures are not available to block transition and change. Yet, structures are also required to harness political will and power to elicit change in the system.

## Culture

### *The current regime: hampering themes*

Regarding culture, two themes are identified as being important factors explaining why integration of service user knowledge is currently limited, including: the dominance of the biomedical model and the influence of stigma.

Similar to high-income countries, formal mental healthcare in LMICs is generally based on biomedical models of care (Saraceno et al., 2007). In addition, this paradigm is often related to paternalistic attitudes of professionals and dependence of service users, based on the presumption that people living with mental illnesses are not capable of making rational decisions. Within this paradigm, objective scientific and professional knowledge are considered valid knowledge while little value is attributed to experiential knowledge of service users (Telford and Faulkner, 2004). Concepts and explanatory models of mental health and illness can vary considerably between cultures, reflecting the norms and values held by societies, communities and individual service users (Herrman et al., 2005). However, culture-specific notions receive limited attention within the biomedical approaches.

Stigma is an important theme affecting the extent to which service user knowledge is valued and integrated. Stigma flags additional barriers to seeking care, alienating people from their communities, and stifling the voice of the service user (Corrigan, 2004). Understandably, the fact that mental illness is highly stigmatized worldwide means that the service user's voice is often lost or devalued. Stigma can be de-motivating for service users, potentially leading them to be unwilling to get involved in knowledge sharing, partly because stigma may be internalized by service users. Stigma may also translate into professionals failing to acknowledge or validate service user knowledge.

### *A shift towards integration of service user knowledge: facilitating themes*

Three themes were identified in the literature regarding culture-related aspects, providing insight into possible pathways to enhance integration of service user knowledge in mental healthcare systems. These themes include: integrating local concepts of mental health,

recognizing traditional models of care provision and a focus on wellbeing. These themes are linked to broader landscape changes in healthcare, including the shift towards demand-centered and needs-based care, and a growing emphasis on wellbeing (Slade, 2010; Tomes, 2006).

First, the responsiveness of mental healthcare with regard to the needs of users might be enhanced by integrating local notions of mental health in care systems (Feierman et al., 2010). Local and culture-specific notions of care strongly influence service users' perspectives of mental health and mental health care, determining the type of care they seek. Understanding the different explanatory models of illness, or reasons for seeking care, provides the platform for professionals and service users to negotiate collaborative treatment (Kleinman, 1980). However, this requires service providers to be reflective of their cultural competences and have an open attitude towards including community members' voices in the development and delivery of services (Swartz, 2007). Furthermore, explaining distress in terms of supernatural phenomena can contribute to reducing stigma. From this angle, local knowledge and beliefs should also be considered as factors in fighting stigma.

Second, in LMICs service users and their families are often more inclined to trust and seek assistance through traditional systems rather than formal mental healthcare services (Saraceno et al., 2007). Traditional models of care foster culture-specific notions and explanatory models of mental health and illness and are more firmly embedded in communities. As preferred care models can be assumed to reflect demands and needs of service users, it would be important to ensure that traditional models are properly recognized in mental healthcare systems. This would additionally create pathways for integrating service user knowledge embedded in traditional systems in mental healthcare systems. As connections between traditional care models and biomedical approaches are increasingly sought (Campbell-Hall et al., 2010), attention should also be devoted to integrating knowledge within traditional systems with knowledge of biomedical systems.

Third, the trend in healthcare focus increasingly on wellbeing instead of illness, might provide opportunities for integration of service user knowledge. For a long time mental health care focused mainly on reduction of illness. However, with the emerging evidence base on the apparent distinction between mental illness and mental health, more and more scholars emphasize the need to develop health services that promote well-being in addition to treating illness (Slade, 2010). A well-being perspective implies a strong focus on the strengths, recovery processes, and individual goals and ambitions of service users instead of biomedical processes. It also entails a more holistic approach to care, acknowledging social contexts and needs of service users. Such an approach seems to connect more to the perspectives, knowledge and needs of service users, and implies a more needs-based approach to care. However, wellbeing-focused approaches have mainly been described in high-income countries and its potential for LMICs has yet to be explored.

## Practice

### *The current regime: hampering themes*

Three practice-related themes are identified as being important factors providing insight into the current situation and barriers regarding integration of service user knowledge: limited collaboration between different stakeholders, professional-service user power differences, and human rights violations.

The first theme addresses the role of other stakeholder that, next to mental health professionals play a prominent role in mental healthcare practices, including traditional healers, faith-based practitioners, NGOs and perhaps most importantly, the service user's social network, namely family and friends. In many countries, traditional healers and faith-based practitioners play a substantial role in mental healthcare. Furthermore, Non-Governmental Organizations (NGOs) play an important role in advocacy and service provision in LMICs (Cohen et al., 2012). In an attempt to help narrow the treatment gap (persons who have a mental illness and require care but who do not receive the care they need) observed in many LMICs, NGOs have stepped in to help address certain needs and gaps in the mental healthcare system, such as lobbying and service provision. In addition, families play a bigger role in the care for people with mental illness in LMICs than in high-income countries (Hanlon et al., 2010). Often, families make important treatment decisions on the service user's behalf, serve as representatives, and are responsible for the ongoing care of their ill relative. Although family members can help service users to articulate their needs and opinions and ensure that this is taken into account, their dominant role is often constraining integration of service user knowledge as autonomy and control are in the hands of the family member instead of with the service user. Currently there is still limited collaboration between the different stakeholders involved in mental healthcare and services remain to a large extent compartmentalized (within the boundaries of disciplines and stakeholder groups).

The second theme involves the large power differences between service users and mental health professionals, which can be particularly challenging for integrating service user knowledge in decisions about their care (Telford and Faulkner, 2004). These power differentials are not limited to, but particularly evident in LMICs, where healthcare professionals are not accustomed to taking into account service user views and preferences and paternalism is particularly strong (Saraceno et al., 2007). These systems of care are often based on a hierarchy where the doctor is considered as holding the only and highest forms of knowledge, without debate or dispute from others. This means that power and autonomy is shifted away from service users who often do not feel equipped to restore this power disbalance.

The third theme regarding current mental healthcare practices involves human rights violations, which are still prevalent worldwide, and more often reported in LMICs (WHO, 2005). Violations might include the use of forced restraint or seclusion,

compulsory treatment, or deplorable conditions in facilities. Such human rights violations often prevent service users from voicing their concern.

*A shift towards integration of service user knowledge: facilitating themes*

Three themes were identified regarding practice-related aspects, providing insight into possible pathways to enhance integration of service user knowledge in mental healthcare systems. These themes include: establishing inter-sectoral collaborations, changing roles and behaviour of mental health professionals and addressing socio-economic needs. These themes are connected to broader landscape changes in healthcare, but also exemplify some initiatives at the niche level, putting pressure on current regimes. Relevant changes at the landscape level include the increasing decompartmentalization (removing boundaries between disciplines, stakeholder groups and sectors) in healthcare (Saltman et al., 2007; Schuitmaker, 2010), empowerment of users in healthcare (Tomes, 2006) and a focus on wellbeing (Slade, 2010).

The first theme involves increasing inter-sectoral collaborations, meaning that potential avenues for collaboration between different types of service providers are explored. Such collaborations are motivated by the need to provide community-based care in regions with limited biomedical resources and facilities. Forming partnerships appear to be promising a strategy, considering that the small body of evidence in this area is beginning to reveal that, different systems of knowledge can co-exist and be respected while simultaneously providing more holistic care to clients (see e.g. Campbell-Hall et al., 2010; Shields et al., under review). Important factors contributing to successful collaborations are trust building, learning opportunities, and mutual learning and openness about one another's practices. More specifically, NGOs are often more responsive to needs arising in the community, leading them to be more inclined to integrate and utilize knowledge from community members, such as service users. Such organizations may provide useful platforms for service user involvement. However, it is important that the uptake of service user knowledge does not remain concentrated at NGO level and diffuses to multiple levels of a mental healthcare system, and in different sub-systems (i.e. the private and public system). Furthermore, family must be included in the dialogue concerning involvement of service users in catalyzing mental health systems in LMICs. The challenge will be to find ways of integrating knowledge from both service users and families, and ensure that service user knowledge is not compromised or overshadowed by knowledge contributed by families alone. In sum, the next steps for these types of collaboration between different stakeholders should include strengthening valuation of different forms of knowledge to improve care, and incorporating experiential knowledge from service users and families.

Secondly, the role and behaviour of mental health professionals, particularly psychiatrists, is slowly changing, which is mainly the result of the decompartmentalization of healthcare and empowerment of service users. This translates to shifts in the power dynamics inherent in service user-doctor relationships, and a shift in roles, transitioning from the

role as a specialist and provider to one of a leader and supervisor. If service user knowledge is to be recognized in mental healthcare, it is important that professionals reflect on their own practices and work towards a model of acceptance with regards to service user expertise and knowledge (Slade, 2010). However, as it appears that such changes are difficult to implement in practice, further research is needed to explore how this shift can be facilitated.

Third, when paying attention to wellbeing instead of merely focusing on illness, sufficient attention has to be devoted to socio-economic needs in relation to mental illness. Service users' socio-economic status is strongly affected by the direct and indirect costs of care, which often results in a downwards spiral into poverty and compromises livelihood opportunities (Patel and Kleinman, 2003). Community-based initiatives at the niche level commonly integrate care-related aspects with livelihood issues. For example, the NGO BasicNeeds uses a social and economic development approach to mental healthcare. They assist service users and their families to access treatment services and provide opportunities to participate in livelihood programmes creating economic opportunities and benefits (BasicNeeds, 2009). By mainstreaming mental health into other sectors - social care, labour, disability - more diverse and practical aspects of service users daily lives and needs are addressed. This likely facilitates the integration of service user knowledge because service users often assign high importance to holistic and social approaches to care (e.g. practical issues of care, issues in daily living) (Telford and Faulkner, 2004).

## Conclusion and discussion

Integration of service user knowledge can be a powerful instrument for developing mental healthcare systems that are more needs based and more responsive. It adds value to mental health policies and services by making them more relevant to practice (Trivedi & Wykes, 2002). Describing knowledge integration from a transition perspective enables a better understanding of barriers and opportunities from different angles and at different levels. The current regime is largely defined by a lack of infrastructure for integrating service user knowledge due to scarcity of policies, legislation and resources, and the institutionalized setting of mental healthcare. In addition, the biomedical model and stigma hamper the recognition and utilization of service user knowledge in mental healthcare. This translated into practices in which service users have limited role in shaping care. Although this dominant regime appears highly resistant to change, increasing pressure is put on the regime by trends at the landscape level, including the decentralization of healthcare, the growing user movement, a shift to demand-based care and a focus on well-being. The regime additionally experiences pressure from the niche level where an increasing number of initiatives take place which experiment with service user involvement. While landscape trends are difficult to influence, niche experiments can potentially be facilitated. We therefore suggest that efforts should be directed to exploring different strategies for

enhancing these so-called niche experiments, while trying to connect to broader landscape trends.

In transition theory three mechanisms are distinguished that can enhance transitions through initiatives taking place at the niche level, including deepening, broadening and scaling up (Rotmans & Loorbach, 2010). All three mechanisms are essential to facilitate transitions, and it is necessary to pay attention to them simultaneously, in an iterative manner. The relevance of the three mechanisms has been described in the context of health systems in general, but has not been applied yet to service user involvement in mental health care. Below, we elaborate on the potential application the different mechanisms in the specific context of integration of service user knowledge in mental healthcare in low and middle-income countries.

*Deepening* involves learning processes which take place in a relatively protected space at the niche level, separate from the regime level. Such experiments could stimulate shifts in organizing, thinking and doing by learning from its processes and outcomes and the identification of best practices. Current studies provide limited insight into the processes and outcomes of service user involvement on service user involvement in both LMICs and high-income countries. Several studies in the UK (Trivedi & Wykes, 2002) have outlined successful case studies of service user involvement in mental health planning, specifically in designing services, serving on commissioning panels, and jointly conducting programme evaluation. Comparable examples from LMICs are limited and we therefore call for such initiatives to be brought forward and contribute to the knowledge base. Additional operational research exemplifying the process of service user involvement, would be beneficial in order to give direction to discovering how integration of service user knowledge can be optimized in LMICs. We suggest that such research projects devote particular attention to skills and competences of service users as well as opportunities for influencing the process and availability of support. Furthermore, outcomes of integrating service user involvement should be specified and thoroughly evaluated, providing evidence for the proposed beneficial impact on care. Literature suggests that specific attention should be paid to the role of change agents, actors with a strong vision and motivation to change, who play an important role in initiating such experiments (Broerse & Bunders, 2010). As these change agents often operate in a multi-actor context, it is important to gain insight in the perspectives of the different actors and facilitate mutual learning between actors within the experiment.

*Broadening* entails linking and repeating niche experiments in different contexts. As a result more actors become involved in the transition and related learning processes, increasing the impact of niche experiments. Important conditions for broadening is that actors in certain niche experiments link up with other actors at both the niche level and regime level. In addition, attention should be paid to the alignment of visions of different actors. This appears particularly relevant in the context of LMICs where the role of the individual service user is often more firmly situated within the context of families,

communities and livelihoods. Embedding service user involvement within broader community involvement initiatives through participatory methods might be a strategy for connecting to local contexts, thereby enhancing knowledge integration. This requires identification of intermediaries or knowledge brokers who can potentially fulfil a bridging role by encouraging and strengthening the voice of the service user and bringing experiential knowledge further. Stakeholders who could fulfil the role of intermediary of knowledge brokers are for example families, activists, NGO staff, traditional or faith-based practitioners, and community change agents (e.g. heads of self-help or microfinance groups). The support of such intermediaries should be coupled with additional attention placed on the knowledge service users contribute and bring forward themselves. In addition, the different perspectives of these stakeholders should be assessed and alignment of their visions needs to be facilitated.

The strategy of *scaling-up* includes activities to embed the new culture, structure and practice at the regime level, requiring fundamental changes at the regime level. Scaling up has been identified as the most challenging strategy mechanism, as strong resistance can be expected from regime actors and many institutional barriers have to be addressed (Broerse and Bunders, 2010). Suggested helpful facilitators include the involvement of key actors at the regime level and connecting to landscape developments support the transition. Currently, in many LMICs, service user involvement initiatives often occur on a small scale, at the niche level, and in absence of a well-functioning mental healthcare system. This bottom-up approach facilitates incorporation of local practices, attitudes and beliefs. However, an important challenge remains scaling up initiatives by structurally embedding it in for instance policy and legislation. Scaling up requires lifting the barriers imposed by dominant regimes, which is most challenging because much resistance can be encountered. Particular attention needs to be devoted to the changing roles and attitudes of mental health professionals, as this is a crucial element for making the transition towards a mental health system in which service user knowledge is valued and fully integrated. Without a shift in competences (knowledge, attitudes and skills) and power of practitioners and policymakers, mental health planning is likely to remain one-sided, excluding service users.

The strategies for transition management described above indicate that experiments at the niche level can be facilitated by drawing more actors and aspects into the so-called transition arena. More specifically, experiments on service user involvement are most likely to lead to changes in mental health systems when they take place in transdisciplinary settings where different types of knowledge and experiences, and different actors are brought together (Broerse and Bunders, 2010). We therefore argue that integrating service user knowledge should be part of a broader collaborative strategy to integrate knowledge from multiple stakeholder groups, although special attention also needs to be devoted to exploring ways of articulating and strengthening the voice of service users. This will contribute to realizing 'good' mental health care which is responsive to the needs of all stakeholders involved.